Health Inequalities Plan
Theme; Health and Wellbeing, and Health Services

Sponsors; Katrina Stephens and John Patterson

15th November 2022

Oldham Council

Agreed Actions

Objective		Agreed action
Have a coordinated approach to prevention and early intervention, supported by a sustainable funding model.	HW1	Develop a coordinated whole system approach to delivering Healthy Weight across Oldham to include a focus on schools to include oral health and to link to existing work around mental wellbeing in schools.
	HW2	Reviewing existing provision and sustainability of investment in early intervention and prevention, including social prescribing.
	HW3	Develop a directory of services for the system to clearly communicate what preventative and early intervention services are available for residents to access, carefully considering the capability and capacity of support available.
Strengthen mental health offer in the borough responding to increase in need during and post covid-19	HW4	Further development of Oldham MH Living Well model, transforming of community MH services. Focus on 'no wrong front door' and MH teams working at a PCN level more focused on population need.
	HW5	Increase capacity for, and equity of access to, addiction services, including developing dual diagnosis pathways.
	HW6	Include questions relating to MH in the NHS Health Check and link patients to appropriate support
	HW7	Evaluate and where appropriate identify funding to sustaining our existing prevention resources e.g. TogetherAll.

Agreed Actions continued

Objective		Agreed action
mprove social upport around the ealth offer, articularly around ebt and benefit dvice and referral nto employment upport rogrammes.	HW8	Work to develop EMIS/elemental referral functionality to make it easier for GPs to refer for social support and behaviour change and showcase at GP training event.
	HW9	Collect and report on primary care data on referrals into social and employment support to target improvements in uptake.
	HW10	Ensure pathways to wider support exist for those who have suffered a serious or unexpected illness which may impact their finances.
mprove access to rimary care for ost vulnerable roups	HW11	Further development of Oldham MH Living Well model, transforming of community MH services. Focus on 'no wrong front door' and MH teams working at a PCN level more focused on population need.
	HW12	Increase capacity for, and equity of access to, addiction services, including developing dual diagnosis pathways.
	HW13	Include questions relating to MH in the NHS Health Check and link patients to appropriate support

Agreed Actions continued

bjective		Agreed action
educe harm used by tomatically scharging people no don't attend ppointments.	HW14	Work with primary, secondary and community care to develop a DNA policy that makes allowances for DNAs due to social reasons and keeps people on care pathways. A specifi focus on children non-attendances as part of this work.
	HW15	Reporting on waiting lists and length of wait by protected characteristics and income level and review the reasonable adjustments that are made for residents where appropriate.
nprove data and telligence on ealth Inequalities inform eventative work	HW16	Work with GM screening and immunisations team to improve Oldham dataset on screening and immunisations to a more granular level of detail so demographic variation i uptake can be understood and action taken.
nprove support nd access to rvices for LD sidents	HW17	Partners to support delivery of the LD strategy and action plan across the borough and ensure that when measuring health inequalities that outcomes for LD residents are reported as a group, drawing on the LD dashboard.

Focus areas for todays discussion

- Oldham Prevention Framework
- Population Health Management
- Living Well
- Focused Care Evaluation

Oldham Prevention Framework

November 2022

Purpose

1. To develop a single shared framework for Early Intervention & Prevention in Oldham

2. To oversee a review of commissioning and grant funding to the Voluntary, Community, Faith & Social Enterprise Sector

Prevention Framework Objectives

- To articulate shared objectives and outcomes
- To ensure prevention is central to everything we do
- To review and make sense of our current early intervention & prevention offer across the system
- To identify gaps
- To avoid duplication and maximise effective use of resources - building on work already done
- To support investment and commissioning decisions
- To support a collective approach to deliver enablers, such as workforce development
- To ensure resident focus and alignment to place-based delivery

Prevention Framework – Development Approach

Phase 1:

- Shared language & terminology
- Shared objectives & outcomes
- Mapping current offer and identification of gaps across the life course

Phase 2:

Agreed plans/approach for:

- Directory of support/services/resources
- Workforce development
- Reviewing and re-designing pathways
- Investment in and commissioning of early intervention services
- Evaluation of prevention and early intervent approaches, services & interventions

Prevention Framework – Development Approach

- Workshop approach
- Representatives from:
  - Adult Social Care
  - ICS (incl. Primary Care Commissioning)
  - Children's Services
  - Education
  - Communities
  - VCFSE
  - Public Health
  - Customer Services
  - Housing Strategy
  - Comms

ham Prevention Framework – Working Draft November 2022

n: People are healthy, happy, resilient and independent

Oldham Prevention Framew

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n: People are healthy, happy, resilient and independent

at's going on? or residents)	What do we offer? (place & services)	How do we define that? (who & why)	What does it look like? (key characteristics)
periencing crisis or complex problems or challenges	Crisis or intensive support services	Intensive support for people with complex needs or in crisis. Keeping them safe, managing problems and reducing impacts.	Acute crisis intervention or plan support. Likely to be multi-ager may be specialist / statutory.
Experiencing problems or challenges	Support services	Bespoke support for people with identified needs. Reducing impacts or stop issues getting worse.	Planned support. May be sing agency / specialist or key work coordinating a range of suppo services.
Staying well spite some risks or concerns)	Some extra help and support; Help to access services for everyone	Targeted offer for people seeking help or at risk. Preventing issues escalating or reducing impact of inequalities.	Self-help. Community based activities and support. Low lev support services available for th who need it. No barrier to acce
ing well / Living well	A good place to live; Services for everyone	Available to everyone. Creating conditions within places and communities for people to be well and thrive.	Social, economic and environme conditions. Accessible service widely advertised. Empowerin people and enabling self-help

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n: People are healthy, happy, resilient and independent

t's going on? r residents)	Objectives (what is needed to achieve the aim)	Outcomes (what should we see if successful)	
		For residents	For services
eriencing crisis or complex roblems or challenges	People are safe and the impact of problems and challenges on their life is minimised so that the level of support can be reduced Services work together to provide the right support at the right time to keep people safe and tackle the root causes of problems	Improved individual wellbeing Reduction in risk and complexity	Coordinated a integrated servi Fewer people n intensive supp
xperiencing roblems or challenges	People have the support they need to reduce the impact and/or tackle problems when they occur and live as well as possible Services work together to provide the right support at the right time and tackle the root causes of problems	Improved individual wellbeing People do not reach crisis or complexity	Coordinated a integrated servi Fewer people n intensive supp
Staying well despite some s or concerns)	Individuals and communities have the capacity to develop, implement and sustain their own solutions to problems and improve their own health, wellbeing & resilience Identify and provide additional targeted activity for populations/groups identified as having the highest risks of poorer outcomes	Reduced health & wellbeing inequalities People are doing more for themselves	Fewer people n support servic People are acces services earlie manage risks
g well / Living well	High quality services for everyone that are open and accessible The environment and community in which people live supports health, wellbeing, resilience and independence	Improved population health & wellbeing People are doing more for themselves	Fewer people n support servic More people a accessing servi for everyone

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Framework Principles

Shared aim for people and places to be as **happy, healthy, resilient and independent** as possible

Strengths-based - built around people not services

Provide the **right support at the right time** – boundaries between levels are blurred

People may be at any level or more than one level, at any time, and move between levels

Work to purpose and outcome – not time or target driven

Built on a **shared system wide understanding of support**

Investment Principles

- Holistic **investment in outcomes** to achieve value – not the cheapest services
- **Commission less, design more** – working with communities
- **Focus investment on prevention** and demand reduction
- Seek to **remove barriers** to effective delivery

Residents First Principles

- Enable people to **help themselves**
- **Residents know how to access support**
- Provide holistic support to **tackle the root causes** of issues
- **Trauma informed**
- **Whole family** focus
- **Coordinated support** – not assessments and hand offs
- **Proactive and curious** professionals

- Initial mapping of current service offer is underway
- Focus on nature of the service and its functions and where they sit within the framework
- Next stage will be to look at the commissioning arrangements and costs
- Mapping approach is flexible to analyse and organise the information in different ways as needed

Theme &/ Life Stage	Service / Provider	Function	Living Well	Staying Well	Problems & Challenges	Crisis or Complex
e.g. Children's Health, Education & Wellbeing	*Name of service & / provider*	*What does this service deliver?*	*At what level of the framework does this function deliver?*			

Population Health Management

Health and Wellbeing Board

November 2022

Oldham Council

What is Population Health Management?

Population Health Management is a data-driven tool or methodology that refers to ways of bringing together health-related data to identify a specific population that health and care systems may then prioritise for particular services.

For example, data may be used to identify groups of people who are frequent users of accident and emergency departments, to offer preventive interventions that improve health and reduce demand on acute services.

PHM priority areas:

For all 5 PCNs:

- COPD
- Asthma
- Diabetes

Additional 3 areas, of:

- Frailty
- Mental Health
- Cardiovascular disease
- Cancer
- Women's health
- Child health
- BAME inequality

What we did – September-November

- Initial meetings with teams from each of 5 PCNs as well as the ICS primary care commissioners
- Discussion of approaches and initial ideas
- Oldham Public Health – research to bring together relevant data on populations, key health inequalities and wider determinants in each of PCN areas
- Also discussions with various council teams and external partners to explore possibilities for joined-up working to optimise linkages – aim to reduce health inequalities in all work
- Presentation of intelligence to PCN teams for discussion – guiding proposed PHM areas and plans

Outcomes so far

- PCNs facing different challenges – variation in uptake of PH support across PCNs
- Positive discussions with GP teams at a PCN Development day – plans made for PHM work to address:
  - Bowel and cancer screening- improving uptake amongst BAME groups to reduce health inequalities in cancer
  - Pathways around AF, hypertension and heart failure – to optimise early management and prevention
  - Cost of living – a key determinant of health inequalities in many of our more disadvantaged populations

Living Well

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Living Well

- The Living well model continues to develop within Oldham, alongside the CMHT transformation.
- The multi-disciplinary team within each of the 5 PCN's is growing as more staff are aligned to each team. This will ensure a more place based and person centred approach to providing MH services in the places where people need them most.
- Referral pathways into the teams are being reviewed so that these are clear and colleagues are aware.

- Mental Health will be a brought to the December Health and Wellbeing Board meeting as a topic for the development session